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ABSTRACT

Strategies for recruitirg physicians to rtral Kentucky communities are presented in troad cutlines that wculd also be applicable to other rural communities lcckirg fcr physicians. After documenting the short.ge and maldistritutich cf physicians in rural America, the factors are descrited which influence a physician's choice of place to locate--his cr her tackgrcund, prcfessional considerations, community rescurces. Five steps in the recruitment effort are detailed: committee formatich, ccmmunity assessment, locating physicians (names and addresses cf journals and agencies to contact plus sample ads), recruiting (including hcw to assess costs), and retaining physicians. Twc sectichs deal with information that shculd te ccvered in interviews and with pros and cons cf employing a search firm. Successes ty small Kentucky tcwns of Morehead and Madisonville in securing high quality medical care are covered, and finally, the alternative tealth care system using paramedical personnel is briefly mentichred, with the example of Hope Medical Center in Estancia, N.M. The appendix ccntains twc maps of Kentucky showing critical medical shcrtage areas and the distritution of physicians by speciality. (RS)

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Rx:

For small towns who need doctors

A MANUAL OUTLINING PHYSICIAN RECRUITMENT STRATEGIES FOR RURAL KENTUCKY COMMUNITIES

JULY 1977

PREPARED BY: WOOD SIMPSON
THE KENTUCKY MUNICIPAL LEAGUE
EXECUTIVE DIRECTOR: R. MICHAEL AMYX

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Kentucky Municipal League

Introduction

Not long ago, a young medical student in Kansas was asked to evaluate the efforts being made to convince him to practice in an isolated rural area. His answer is instructive to all small communities in need of a physician, because it reflects an attitude most medical students share.

"In the medical center," he said, "the concept of the rural medical doctor is that of a rather unsophisticated, overworked and marginally competent practitioner who turns over all but the simplest of his patient care problems to the Ivory Tower. In general, many students view rural practice as a situation in which the physician is overworked, medically isolated and never has a vacation. It is thought that his children attend second-rate schools, that he faces lifelong cultural and social deprivation, and that his wife complains about his 24-hour-a-day call schedule--in addition to everything else. So, at the end of four years of medical school and several years of post-graduate training in the urban medical center complex, with all of the attendant medical, educational and social

advantages, the young physician must indeed be highly self-motivated to seek a rural practice."

Although it would be a great oversimplification to suggest that this attitude alone is entirely responsible for the shortage and maldistribution of physicians in rural America, it does pinpoint some of the primary concerns of the young men and women whose services are so desperately needed now in our small towns.

How desperate is the need?

Nationally, statistics show that there is a higher proportion of people with disabling chronic disease living in farm areas than anywhere else in the nation. In addition:

--There is a greater number of bed disability days suffered per person per year in nonmetropolitan areas.
--In some rural counties the infant mortality rate is double that of the national average.
--The number of short-stay hospital discharges, indicating the need for hospitalization, is higher in rural areas.
--And finally, the accident fatality rate in farming is higher than in any other occupation, except mining and construction. In Kentucky, where many persons on farms are working with horses, the accident rate may run even higher than the national average.

Despite various scholarship and preceptorship programs

designed to alleviate the problem, the rural physician shortage is getting worse. Country doctors are older than urban doctors, so they are retiring and dying at a faster rate--and they are not being replaced. A study of three successive medical school classes throughout the U.S. indicates that only six percent of the graduates set up practice in counties of less than 50,000 population, although such counties represent 19 percent of the national population.

In Kentucky, the problem of physician maldistribution is particularly acute. The U.S. Department of Health, Education and Welfare surveyed the state in 1976 and determined that there are large sections in the eastern and western parts of the Commonwealth which meet the federal criteria for designation as a "Critical Medical Shortage Area." These underserved areas have a physician to population ration of greater than 1:4,000. For the purposes of the study, a physician was defined as a doctor who specialized in one of the five primary care categories--that is, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.

In all, the HEW report identified 52 counties with a critical shortage and one county (Robertson) which had no physicians at all.

As a result of this shortage, small towns have been reduced to running large want ads in state newspapers, spending large sums with physician recruitment firms, who may offer no specific performance guarantees, and other dubious measures. A Rural Medical Scholarship Fund, which

has been established at the state's two medical colleges in an effort to lure young doctors back to rural areas, has had little success. And since less than half of the graduating physicians at the relatively new University of Kentucky Medical School choose to remain in Kentucky--with only a handful of these doctors going to isolated communities--the situation is slowly deteriorating.

The plain fact of the matter is that no small town in need of a physician is likely to have a successful recruiting experience--or even retain the doctor it already has--unless it understands what the most important factors are in the physician's choice of a place to locate. For convenience, these factors may be classified in three groups:

--Physician's background.
--Professional considerations.
--Community resources.

PHYSICIAN'S BACKGROUND

The best documented and probably the most influential factor seems to be the community background of the physician. Studies indicate that practice in a small community is more likely to be the choice of doctors who grew up in small communities themselves. Nearly half of the physicians, in fact, who practice in towns of less than 2,500 are from towns of similar size. And a physician with such a background is also more likely to choose general practice instead of a specialty.

In addition to the importance of family and friends,

the family member of special significance is the physician's wife. Wives of rural physicians, like their husbands, are more likely to have a rural background. In addition, many wives today may require a meaningful professional responsibility outside of the home. This requirement should not be underestimated by physician recruiters and the definition of available opportunities for the wife should be a high priority.

The location of the physician's medical school and internship and residency training also seems to influence his practice location; those who train in urban places tend to locate in urban areas. This is one good reason for encouraging the development of more training facilities in rural areas. The role of graduate teachers and older physicians cannot be overlooked and the presence in medical colleges of physicians from rural practices could be a significant factor in influencing young students to seek rural opportunities in health care.

Professional Considerations

Factors directly related to a physician's practice also enter into their decisions about location. An overwhelming majority of new physicians now prefer group practice. And what is perhaps more important is that three out of four established physicians, if they had it to do over again, say they would also choose group practice.

Economic and transportation advantages probably make group practice easier to establish and maintain in urban areas. That is, there is more likely to be a larger number of nonindigent patients, and they are more likely to have

ready access to transportation in urban areas. If group practices actually are easier to join, to establish, and to maintain in urban areas, this could represent an important factor in the unequal distribution of physicians. Furthermore, it is a factor that probably could be manipulated through community or federal action; programs of financial and management assistance for rural group practice might be of significant value.

As the statement made by the young medical student from Kansas indicates, professional isolation is feared by students and various aspects of isolation--lack of clinical support and lack of free and informal communication with medical peers, to mention a few--are cited as important factors in deterring physicians from rural practice.

One facet of the isolation may also be the lack of variety in medical problems to be treated. It is estimated, for instance, that upper respiratory problems comprise a majority of the complaints in rural areas. But perhaps the most forboding aspect of being an isolated rural physician is the long hours and the absence of free time. It makes no sense to sing the praises of your area's recreational opportunities if the physician will have no time to enjoy them.

Community Factors

The setting of the practice appears to affect location

choice. To be attractive to a physician, a community must offer him economic security and the resources with which to enjoy his precious leisure time.

One of the chief reasons physicians go into small community practice is the likelihood of developing a busy practice early. The economy of the community may, therefore, be an important determining factor in the choice of location. While studies have shown that there exists a positive relationship between regional per capita income and the supply of physicians, those analyses have usually been done on county or state levels and may not be entirely relevant to the problem of the small communities within these boundaries.

At least one study, however, has indicated that slow or declining economic growth rates are characteristic of towns without physicians and, in another study, the median income of a community's population was significantly higher for towns gaining physicians in a 20-year period than for towns losing physicians.

The important thing to remember about this is that towns with a low median income or an otherwise poor economy are in an unfavorable position for attracting or retaining physicians. On the other side of the coin, however, rural physicians seem to make as much money as urban physicians--although the city doctors are often not aware of this.

Such negative factors as the scarcity of recreational and cultural opportunities may be more than offset by the absence of big city hassles, the clean air, the open spaces, the friendly people and the charm of living in a small Kentucky town.

Summary

Despite the fact that many influences have been identified as relating to the problem of the "vanishing rural physician," the problem itself is increasing rather than being solved. As yet, there has been no universally successful and acceptable solution proposed. A manual such as this may provide broad guidelines for physician recruitment, but it is the individual community, in the final analysis, that must gather its collective resources together and shape its own recruiting formula.

Five Steps

There are five steps to be considered as a recruitment effort is launched. They are:

--Form a recruitment committee. It should be composed of individuals with experience in business, law, banking and, if available, a representative from the local medical profession. Remembering the significant influence of the physician's wife, one or more women should serve on the committee.

--Take a good long look at your town and what it has to offer, keeping in mind the prejudices you are likely to encounter from young men and women like the student from Kansas.

--Locate interested physicians.

--Decide on the best method of approaching the candidates and what the recruitment effort is likely to cost--not only in "up front" recruitment costs but in the provision of fringe benefits, such as free rent on medical facilities or a home, membership in country clubs and whatever else seems appropriate.

--Recognize that the effort should not end with finding a good candidate. Many towns are losing their physicians due to deteriorating economic and cultural conditions, and much of what is written here applies equally to retaining physicians as it does to recruiting new ones.

Several of these topics will be discussed generally below, but this should only be considered as a start. The rest is up to the ingenuity and hard work of the community groups responsible for the effort. All stand to gain; all should get involved.

Community Assessment

There are certain hard facts which should be considered by any community before it launches into a physician recruitment campaign. A look at the present situation and an examination of the area's future will be important determinants of your ability to attract and keep physicians. The statement that you have "always had a doctor in town" must be considered in light of changes that may have taken place since that doctor came to the area. Although you will be gathering the following information for your own assessment of the situation, it will be useful to have as you approach candidates later.

One of the questions you must first address is whether your town and the surrounding community can support a physician. Though many attempts have been made to suggest a minimal number of persons necessary to support a physician, they have failed because they do not take into account the many variables of an area, such as financial stability and the ability of area residents to pay for a doctor's services. Despite the difficulty in accurately predicting a "minimal number," however, it may be worth knowing that a senior official at the University of Kentucky Medical Center suggests a 3,000:1 ratio. For the sake of comparison, the ratio of physician to population in the Lexington-Fayette Co. Urban Area is about 400:1.

In order to determine the financial stability of your area, rough data could be gathered from interviews, surveys or common knowledge about how many people in the area go how far to obtain what medical services. Some interest should be paid as well to the future population of the area and whether a doctor could be supported ten to twenty years from the present.

Another important question is whether the community is the type of place in which a physician and his family would like to live. One of the best ways to think about this is to ask yourself why YOU like to live and work there. Your responses should give you a clue to whether a physician would find the area attractive.

Yet a third issue with which you should be concerned before starting the search is whether the residents are able and willing to make provision for other kinds of support a physician will need in order to stay in the community. Such things as opportunities for continuing education so he or she can keep abreast of new trends in medicine, a mechanism for professional exchange with other colleagues in the area, a provision for vacation time, assistance from perhaps another physician on days off or from support personnel, such as a physician's assistant or a nurse practitioner.

If you are immediately discouraged by the prospects of your community's securing a physician, perhaps you should consider from the outset alternatives such as utilizing a nurse in an expanded role as a provider of primary care. Normally, such physician extenders must be employed by a medical doctor, so it might be worthwile to approach a physician in a nearby community with your concern. More about the

potential of the physician extender-nurse practitioner in the last section of this manual.

If you are satisfied that you have what it takes to attract and keep a physician, you are ready to proceed with the next step.

Locating Interested Physicians

There are several approaches to this, any or all of which may be pursued according to budget limitations.

1. Prepare an advertisement for submission to the following addresses. This will assure widespread publicity of your search.

Journal of the American Medical Association
535 North Dearborn
Chicago, Ill. 60610

The D.O.
212 E. Ohio Street
Chicago, Ill. 60611

Medical World News
Mrs. Helen Reagan
1221 Avenue of the Americas
New York, N.Y. 10020

Air Force Military Personnel Center
Randolph Air Force Base
Universal City, Texas

The Kentucky Medical Association Journal
3532 Ephraim McDowell Drive
Louisville, Ky. 40205

Examples of advertisements appearing in a recent journal suggest the type of content which is included (but it would be better to buy a few recent issues to get a line on the "market").

GENERAL PRACTITIONER NEEDED FOR MEDICAL SERVICE--a community of 2[illegible],000, drawing area of 60,000; superb hunting and fishing in the heart of coastal recreation.

FAMILY PHYSICIANS FOR EXPANDING RURAL AREA--health programs in clinic settings; no investment needed; excellent facilities in associated fully accredited hospital with all specialty consultants available; income guaranteed initially; excellent opportunity for all recreation; full details from Administrator, Maine Coast Memorial Hospital, Ellsworth, Maine.

An anecdote at this point illustrates the importance of ingenuity in the recruitment process: After exhausting normal advertising sources with no results, one small Kentucky town took a chance. They placed an ad in the Sunday New York Times (a good day to catch doctors at home?) and, to their surprise, received dozens of responses. Eventually, they recruited a husband-wife team, both physicians.

2. Contact hospitals and clinics where there are internships and residencies. This approach would be preferable to contacting medical and osteopathic schools if you need a

physician now or in the very near future, since interns and residents are almost ready to go into practice.

The American Medical Association and the American Osteopathic Association have registries and residency training programs (many of which are not directly connected with medical schools). Write both agencies--but in choosing places to write or visit, it might be best initially to concentrate on areas with similar climates and on programs in family practice.

You may wish to include with your letter a publication from the Chamber of Commerce or some other descriptive material on Kentucky in general and your area specifically. Many persons know very little or have substantial misconceptions about rural areas in Kentucky and are, therefore, not aware of the attractions and benefits of living here. This material would also be good to have whenever you talk to a candidate.

3. Contact medical and osteopathic schools to attract upcoming graduates if your need for a physician will be several years in the future. This may be accomplished by letters asking the recipients to post the letter on a bulletin board.

You may also wish to visit some of the schools and speak directly with students. An advance letter is in order to inquire when would be the best time to come and whether something might be arranged so students would know you are coming and be available to meet with you. It would also be a good idea to ask specifically for the names of students who come from your part of the state. These students can be identified for you by the following officers at the state's

two medical schools:

Associate Dean for Student Affairs
School of Medicine
University of Louisville

Associate Dean for Academic Affairs
School of Medicine
University of Kentucky

4. Contact medical and osteopathic associations in areas where some situation such as an economic crisis is causing people to leave--for instance, a military base or big industry may be closing down.

5. The National Health Service Corps is a federal manpower deployment program which assigns personnel, including physicians, dentists, nurses and support personnel to areas where health services are inadequate. It is generally conceded that the Health Service Corps prefers to send two doctors to an area which means, again, that you must be able to demonstrate a large enough population to deserve their services.

Communities may submit applications to the Corps directly. Write for information to:

National Health Service Corps
U.S. Public Health Service
50 Seventh St. NE
Atlanta, Ga. 30323

Ask for the brochure entitled "The National Health

Service Corps--Some Questions and Answers" and for the application forms. If technical assistance is needed in preparing the application, contact your Area Development District Health Manpower Planner, or the Kentucky Municipal League.

6. Contact the Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Ky. 40405, and ask for the most recent copy of their "Biographies of Physicians Seeking a Location in Kentucky." These are prepared from inquiries to the Association from physicians and contain a variety of background information on each physician, including place of training, internship, residency and specialty, if any.

7. Contact physicians who are taking the medical licensing examination. Many physicians already know where they will locate by the time they come to Lexington or Louisville to take the examination. But sometimes there are others who are undecided. Community representatives can come to the exam site to be available to talk with interested persons during the evenings of the three-day examination periods.

Calculating Costs

The financial outlay for recruitment does not compare with the outlay of man hours necessary. The following list of expenditures, however, may help you assess a dollar amount:

--Price of advertisements.

--Cost of air fare and expenses if you choose to visit

medical schools.

--Cost of air fare and expenses if you bring candidates (and their wives/husbands) to the community for interviews.

--Moving expenses for the physician.

--Cost of guarantees which you may decide are necessary to attract a physician.

--Cost of fringe benefits, such as medical facilities, favorable mortgage rate, free rent, free malpractice insurance, etc.

--Cost of doing business with a professional physician recruitment firm, if you decide to take this route (see cautions in section on this subject).

Interviewing

Once you have a lead on a potential candidate you will need to meet with him/her. It is ideal if you can bring the candidate to your community to meet with area residents and get an exposure to the community. This is an opportunity to give the candidate a taste of small town hospitality and, surely, this is one of the places where Kentuckians traditionally shine. Be sure, however, to verify the candidate's credentials before meeting him. Ask for the following information when they submit their list of references:

1. Title and address of licensing board.
2. Title and address of state and local or county medical or osteopathic societies.
3. If they are interns or residents, the name and address of the Chief of Service in the hospital where their training is taking place.

In addition, you should check the local bank and the Chamber of Commerce for any information they can supply about the individual.

After the arrival of the candidate, you should be prepared to discuss the following information about your

community with the candidate:

--Demographic information (population, ethnic groups, socio-economic data, any special characteristics such as high percentage of elderly).

--Geographic features (altitude, terrain, distance to urban areas).

--Recreation facilities and possibilities.

--Schools and churches.

--Types of industry, or how people make their living.

--Growth information (is the community stable, growing, etc.).

Of particular interest to a physician is health related information: What facilities are there? How far to specialists and what type are they? What are the vital statistics, including infant mortality rates? What types of payment plans are there? Your ADD planner or County Health Department should be able to obtain this data.

Oftentimes, in an effort to make the community attractive, another issue is overlooked. That is the uniqueness of the opportunity or the challenge of the job. The president of a theological seminary said recently that one of the reasons recent graduates are finding employment outside of churches is that communities are approaching them with offers of money, fine housing and security rather than with an indication of the challenge and the problems involved in being a minister in that town. The comforts of life were not why the young men and women chose to become ministers. So they go instead to ghetto areas. It seems possible that some young medical

school graduates imbued with a sense of dedication and an interest in being of service where they are most needed might respond best to this kind of appeal and such an approach would assure that the candidate you attract would fully understand the negative, as well as the positive, implications of becoming your doctor.

This also is the time to give due consideration to the physician's wife. Ask what her interests and favorite pastimes are and see if your community can satisfy these.

Many communities find it helpful (or necessary) to offer guarantees of some type, and many candidates require these. One community, for example, offered $2,000 per month guarantee for the first year to allow the physician to build his practice. Other communities have offered twice as much (the most recent advertisement seen in area newspapers from a small Kentucky town offered $57,500 annually, including malpractice insurance and "no experience necessary": At last report there were no takers!).

Whatever amount you choose to guarantee, it should be determined after a careful assessment of the "market," either through conversations with other physicians and municipal officials, or review of ads in medical journals. Some communities provide free rent for clinic facilties or free rent for housing for a period of time, as mentioned previously, and keep in mind: the candidate you are recruiting has just completed years as a student and intern with little or no income, so anything you can do helps.

Remember that you are interviewing the physician, as

well as being interviewed. Decide what you would like to know about him and ask it. Lastly, a word of caution.

Be sure that your desire to obtain a physician does not override your good judgement in choosing one. A bad physician is worse than none at all, so take every precaution you can to ensure that you make the best possible decision in hiring the man who literally will have your life in his hands.

Search Firms

The Kentucky Municipal League has been asked in the past to investigate the backgrounds of professional physician recruitment firms who approach Kentucky cities. One small town in Western Kentucky that lost its only doctor was approached by a California firm with a "bargain basement" offer to find a doctor.

For $4,000 in advance, the firm promised to seek out so-called qualified doctors for the town--however, no time limit for this service was specified. It was also learned that many of the physicians "found" by the firm were trained in Indo-Chinese doctor mills, where graduating classes may run over 1,000. Medical school officials in Kentucky say small towns ought to be careful in determining whether a physician trained in the Far East, the Phillipines, South America, Mexico or Africa would be suitable for a rural Kentucky community. And while a few of these physicians may manage to meet minimum AMA standards, substantial questions remain regarding their actual skill as physicians.

The League, therefore, recommends that where physician

recruitment firms ask for funds "up front" with no specification of a time limit for their services, a performance bond in the amount of one-half of the total contract should be posted by the company. At present, reputable recruitment firms charge a fee in the neighborhood of $16,000 to $18,000, but contracts may vary widely. Be certain the contract stipulates:

--A guarantee of replacement if the physician does not stay for at least a year; and,

--An option which permits the town to refuse the doctor if the people find they can't live with him.

Once again, it is important to remember in dealing with the professional search firms that the days of solo practice in an isolated area are just about gone. It is neither in the best interests of the physician or his practice to require him to be available 24 hours a day, 365 days a year. A recruitment firm may very well find a single physician to settle in your town (thereby earning its fee), but the physician won't stay long--and may not live long, either--if he does not have adequate time off for rest and recreation.

The Municipal League has the names of several recruitment firms that have had experience in Kentucky and who were recommended by the University of Kentucky Medical School. Names and addresses will be supplied upon request.

Two Successes

As mentioned previously, the traditional model of solo practice family doctors located in small communities and isolated from other physicians is no longer viable. The emerging medical practice model is characterized by group practice, participation of physician extenders, increased emphasis on medical technology and a larger population base. Less than half of the doctors in the nation today fall under the family practice heading and more and more doctors are choosing to spend from three to five years in post-graduate training to learn one of the specialties. These specialists typically practice near large medical facilities, where they have access to the highly sophisticated equipment needed in modern specialty practice.

In order to accommodate the health delivery system to greater centralization of providers, other services are developing. The emergence of well-trained emergency medical technicians and out-reach clinics for primary care are examples of accommodation taking place within the system.

Efforts to attract physicians and other health care providers to underserved areas need to be based on a realistic

appraisal of the area and an understanding of changes in medical practice and health care delivery. In the last 30 or so years, doctors have tended to cluster in the highly lucrative suburbs, where group practices lessen the work load and administrative burden and where high-income groups can afford the luxuries of elective surgery and very frequent doctor visits.

While we believe that present community recruiting efforts are generally ineffective, in part, because they do not reflect an understanding of this trend, there are striking exceptions. Two towns in Kentucky which have had success in securing high quality medical care are Morehead and Madisonville.

In Morehead, a college town of about 8,000, the development of a sophisticated, highly specialized health care system has stemmed from a local desire to have the best and from a commitment by the University of Kentucky medical school, as well as the willingness of a Catholic order to take on a big job in a predominantly Protestant area.

Before 1963, Morehead had four doctors and no hospital. People with more than minor ailments had to be sent to Lexington, about 60 miles away. One of the town's doctors, however, established the St. Claire Medical Center with 41 beds under the administration of the Sisters of Notre Dame in Covington. Today the hospital has 170 beds and the staff of doctors has grown to 40.

In Madisonville, two brothers established the Trover

Clinic 24 years ago and it now serves 27 Western Kentucky counties. Although Madisonville has a population of only 17,000, the Trover Clinic has 61 doctors, 43 of them specialists.

The trend is unmistakeable. Regional hospitals surrounded by a constellation of outreach clinics and serviced by roving teams of emergency medical technicians are the best contemporary mechanism for attracting high quality medical practitioners, while small, uneconomical county hospitals, with outdated equipment and medical techniques, seem to be passing slowly from the scene.

Alternatives

If a small community encounters serious problems in locating one or more physicians for a local clinic, and the prospects for the future don't look good, then it may be time to look into alternative health care systems, using paramedical personnel.

The Hope Medical Center in Estancia, N. Mex., exemplifies a medical clinic operated at a great distance from a medical center (60 miles from Albuquerque) by a non-physician staff. The person in charge is called a nurse practitioner--that is, a registered nurse with one or two years of additional, specialized training.

Primary medical services are provided to a population of about 800. No surgery or setting of fractures is performed, and all major cases are referred to Albuquerque.

The nurse practitioner performs physical examinations, suturing and splinting. She takes samples for laboratory work, which is then done either by the county health department or at the medical school. She takes x-rays that are sent to the medical school and ECGs (electrocardiograms--used in diagnosing abnormalities of heart action) are transmitted

by telephone and read at the school. She writes prescriptions that a physician from the medical school countersigns.

A direct telephone line links the center and the medical school where a physician is always available for consultation. Two physicians from the medical school visit the center weekly--a pediatrician each Friday and another physician every Tuesday. One room at the center is equipped for dental services, and a dentist visits the center twice a week, on Tuesday and Thursday, for half days.

In addition to the nurse practitioner, the center is staffed by a licensed practical nurse who is a laboratory technician and a clerk. The project has the support of the state medical association, and it has been reviewed by the state nursing board, as well as the state attorney general to assure its legality.

Other Problems

A final note to towns in need of a physician even though they may already have several established:

One of the great difficulties in adding new physicians in a community already blessed with several is the resistence frequently encountered by the older doctors in town. At a recent medical conference, a physician spoke of the reluctance of physicians to change their style or to accept new ideas relating to the delivery of medical care.

"I've taken medical students to discussion meetings," he said, "and I'm disappointed how difficult it is for the established medical community to think in terms of the expectations of young men and women. There really is a generation gap. Practitioners adhere to their individual practice, their individual patients, and they are reluctant to become involved with group practice or even to share in calls. Our students can't believe this, and they just go away. A young man isn't going to go in and fight that battle alone."

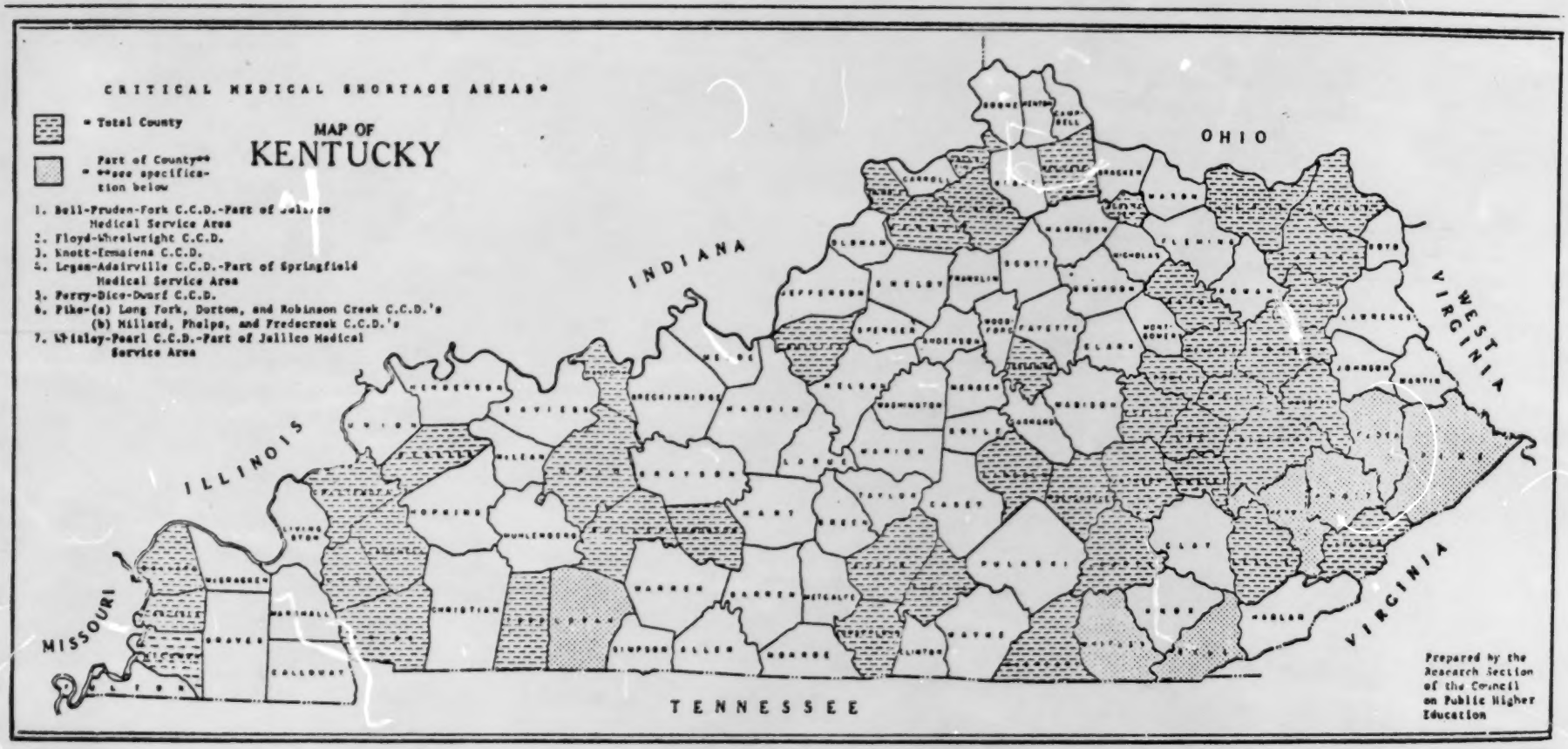
It is important, therefore, to consult with the older physicians before inviting new candidates to your community.

Note on the Appendix

To give city officials an idea of what the physician maldistribution problem looks like statewide, two maps have been appended to this manual.

The first indicates the "Critical Medical Shortage Areas" in Kentucky as defined by the U.S. Department of Health, Education and Welfare.

The second shows the distribution of physicians by specialty. In this map, the Area Development Districts are used to define the boundaries of the survey. Primary care has been defined previously; Secondary care includes such specialties as Ophthalmology, Cardiology, Psychiatry and Neurology; Tertiary care includes more advanced specialties, such as Thoracic, Plastic Surgery and Neurosurgery. Note how few of the specialist practitioners are distributed in rural areas.



**U.S. Department of Health, Education and Welfare (Federal Register. July 6, 1976). Critical shortage areas are determined by a practitioner to population ratio of greater than 1:4,000 of primary care physicians (i.e., General Practice, Internal Medicine, Pediatrics, Ob/Gyn, and Family Practice) in a given area.

APPENDIX A

DISTRIBUTION OF PHYSICIANS BY SPECIALTY BY AREA DEVELOPMENT DISTRICTS*
KENTUCKY
AREA DEVELOPMENT
DISTRICTS
● INDICATES DISTRICT OFFICE LOCATION
# of Primary Care Physicians
# of Secondary Care Physicians
# of Tertiary Care Physicians
BLUEGRASS
BUFFALO TRACE
NORTHERN KY.
FIVCO
KIPDA
LINCOLN TRAIL
GREEN RIVER
TEWAY
BIG SANDY
PENNYRILE
PURCHASE
KY. RIVER
BARREN RIVER
LAKE CUMBERLAND
CUMBERLAND VALLEY
188
107
5
24
0
0
784
369
67
49
15
1
62
9
0
550
252
41
120
31
5
87
18
0
34
6
0
19
0
122
39
6
77
10
0
119
24
0
107
31
4
104
30
3
*Data supplied by the Medical Licensure Board, and were collected during the 1975 relicensure cycle.
Prepared by the Research Section of the Council on Public Higher Education

APPENDIX B